Dr. M. Scott Peele, DDS, PA
1087 Hendersonville Road Asheville, NC 28803
Phone (828) 274-4747 Fax (828) 274-4715

OFFICE POLICY

Thank you for choosing Dr. M. Scott Peele. Our primary mission is to deliver the best and most comprehensive dental care available. We appreciate and care for all of our patients. If you have any questions or concerns, please feel free to discuss them with us.

-Payment in full is expected at the time services are rendered. There will be a service charge of $35 for any returned check. Also, monthly finance charges of 1.5% are charged to delinquent accounts after 60 days. Should a delinquent account be turned over to our collection agency, we reserve the right to apply the agency's fee to the patient's account.

- For patients with insurance- We will file your insurance for you, but **the estimated patient portion not covered by insurance is due on the day we begin treatment .** We try to be familiar with the regulations and restrictions of each company; however, the **patient** is ultimately responsible for understanding the details of the insurance plan and for payment of treatment not covered by insurance. It is your responsibility to present your current insurance card to us at each visit and to notify us promptly of any changes in name, address, phone numbers, etc. We reserve the right to require payment from you if your insurance company does not pay within 60 days from the service date.

For your convenience, we do accept the following:
Cash, Visa, Master Card , American Express, Discover , Debit Cards

No Interest Payment Plans from Care Credit 6, 12 months available (subject to credit approval).

-We make every effort to schedule a convenient appointment time for you, if you must cancel please notify us at least **24 hours prior** to your scheduled appointment. If you do not , there will be **a $35.00 fee** added to your account for that day. If you are running late, please call and let us know. We reserve the right to reschedule your appointment if you are late.

Whom may we thank for referring you? _____
Method of payment for today's treatment? Cash__ Check__ Debit__ Charge_____

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I have read and understand the Office Policy and agree to the terms. I have received a copy of Dr. M. Scott Peele's Notice of Privacy Practices.
Please list the names and relation of persons who may receive information about your account or dental records, such as spouse, relative, legal guardian, etc.

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Patient, Parent or Guardian Signature_____ Date_____
Patient Name **(Please Print)**_____